Florida Medicaid Managed Care EMS Supplemental Payment Program Informational Session

August 21-22, 2019

PUBLIC CONSULTING GROUP

Florida Fire Chiefs' Association

Introductions

Florida Fire Chiefs' Association

- Ray Colburn, Executive Director
- Darrel Donato, President

PUBLIC CONSULTING GROUP

- Matt Sorrentino, Manager
- James Dachos, Associate Manager
- Alissa Narode, Senior Consultant
- Luke Taffuri, Consultant

Better Health Care for All Floridians
AHCA.MyFlorida.com

- Brooke Yowell, Regulatory Analyst Supervisor

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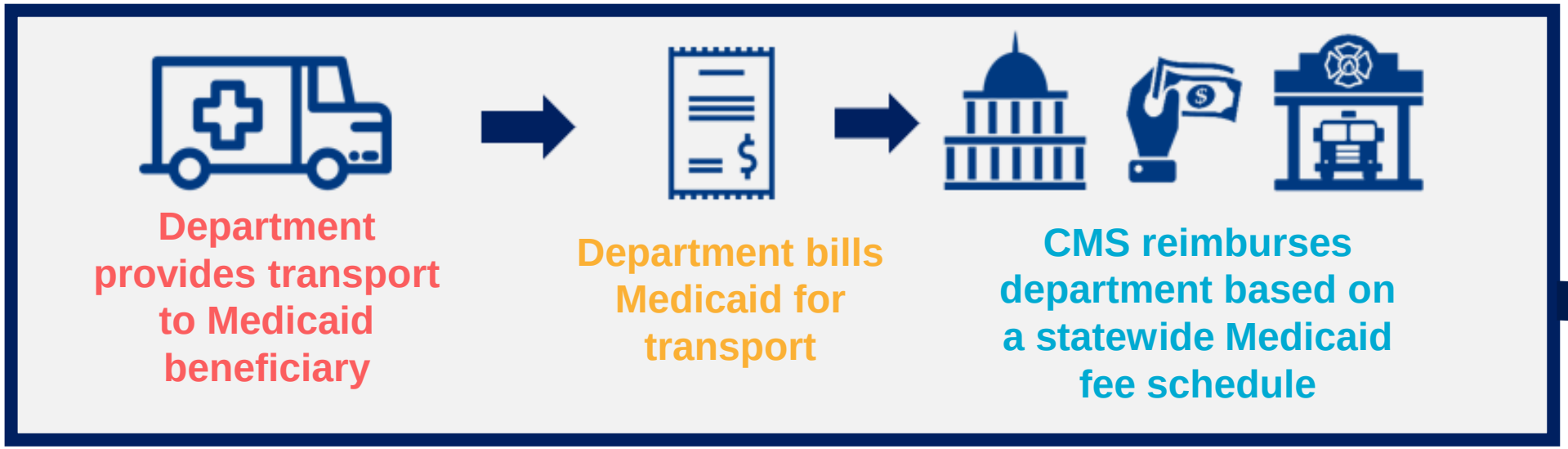
Program History & Overview of Funding Authorized by Legislature

Program History

A Medicaid supplemental program was established to address Medicaid payment inadequacy.



Medicaid payment rates do not recognize the actual costs incurred by EMS providers for the provision of EMS services

- Typically the rate at which Medicaid transports are reimbursed is **25% or less** of the actual cost of services
- This requires municipalities and counties to use **alternative funding sources** to supplant the costs incurred through other funding mechanisms, such as the allocation of taxes and fees

Program History

With leadership from FFCA and collaboration with AHCA, effective for state fiscal year 2016 the **Public Emergency Medical Transport (PEMT)** Medicaid Fee For Service Program was established.

Fiscal Year 2016

- Direction on allowable costs was finalized
- Indirect Cost Rate approach was clarified
- Trust Fund was replenished to make an additional payment
- Additional time was given to complete (deadline extended)
- Requested additional detail/information post-submission

Fiscal Year 2017

- No major changes to methodology or direction
- Followed year 1 directions and modifications
- Trust Fund increased, but there was a shortfall in payments that necessitated a "haircut"

Fiscal Year 2018

- Additional providers will join (last year 58 providers participated)
- Expected audit and findings will change some methodologies
- Additional money ($35M) was set aside in the Trust Fund
- Federal share of the final distribution amounted to $27.7M

Program History

The PEMT program was a great first step to address the challenge of current Medicaid reimbursement rates.

- However, Medicaid Managed Care reimbursement levels remained at inadequate levels.
- Medicaid managed care transports represent ***91.4% of total transports***.

Program	Transports	% of Transports
Medicaid FFS	25,957	8.6%
Medicaid Managed Care	276,213	91.4%
Totals	**302,170**	**100%**

As a result, FFCA championed a legislative effort to obtain approval and new funding to establish a Medicaid managed care supplemental payment program.

- PCG worked with FFCA to develop the mechanics of the program and provide technical assistance.

Summary of Legislative Session

FFCA successfully obtained funding for the Managed Care Supplemental Payment program, as well as preserved the current PEMT program.

- $89M in funding was approved in State Bill 2500, which was signed by the Governor DeSantis on 06/21/2019.
- Medicaid Managed Care (MCO) Payment Program – Established a $54M (all funds) funding pool, but requires a different state share funding mechanism through intergovernmental transfers (IGTs), as well as requires payments to be made by Medicaid managed care organizations (MCOs).
- Medicaid FFS program – Maintains $34M in Medicaid supplemental payments financed through CPEs. Exactly how the current PEMT operates today.

Program	Funding
Medicaid MCO*	$54,786,711
Medicaid FFS	$33,213,289
Total Medicaid	$89,000,000

Represents Total Funding amounts Federal and State Share.

- **$33,677,391** in ***new federal Medicaid funding*** established as a result of this effort!
- A **100% increase** in Medicaid federal funding available to the government owned Fire & EMS community!

Comparison of Supplemental Payment Programs

PEMT Fee For Service

1. Requires Providers to submit a ***Medicaid cost report*** on an annual basis.
2. Providers receive a Medicaid supplemental payment on difference of Medicaid cost compared to Medicaid payments received from AHCA.
3. Medicaid supplemental payment is ***provider specific***.
4. State share is provided through a ***certification of public expenditures*** (no transfer of funds).
5. Process repeats on an annual basis.

Managed Care

1. Medicaid managed care supplemental payments are made based upon ***transports, tied to utilization***, and will be made on a ***quarterly basis or schedule approved by AHCA***.
2. Medicaid payments ***are not provider specific***, as CMS requires consistent payments across provider classes.
3. Medicaid payments are made by ***Medicaid managed care organizations (MCOs)*** and not by AHCA.
4. Providers have to ***fund and transfer the state share*** through an ***intergovernmental Transfer (IGT)*** to AHCA.

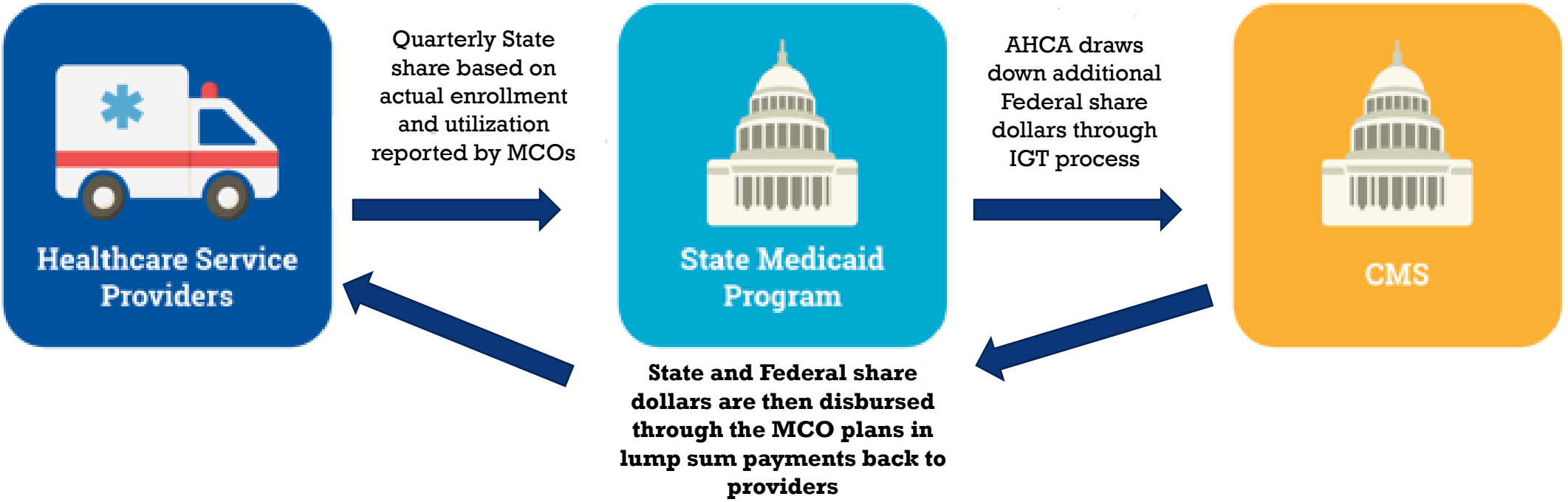
Medicaid Managed Care Supplemental Payment Program - State Share Funding Requirements

Overview of IGTs

Intergovernmental transfers (**IGTs**) are a transfer of funds from another government entity (e.g., county, city or another state agency) to the state **Medicaid** agency.

- This provides a guarantee of federal matching funds for state expenditures for health and long-term care services for the country's low-income population.

- IGTs are the backbone and necessary for the success of the Medicaid managed care supplemental payment strategy – If providers do not IGT, it may impact the viability of the program.



History of IGTs in Florida and other Medicaid financing

- IGTs has been a mechanism used by Hospitals in Florida to fund the Low-Income Pool (LIP), a similar Medicaid supplemental payment program.
- IGTs have been used to increase Medicaid payments to publicly owned physician practice plans that are part of state medical schools.
- IGTs have been used by Nursing Homes to enhanced Medicaid rates.
- Most, if not all, Medicaid Supplemental programs have some sort IGT financing arrangement with safety net and/or public providers.

IGT Letter of Agreement Form

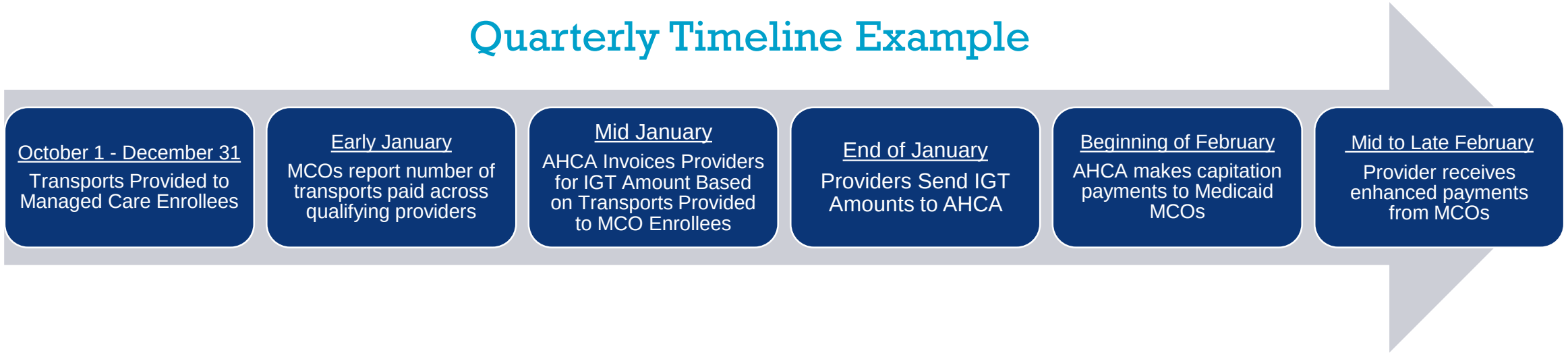
AHCA facilitates IGT participation through the letter of agreement (LOA) form.

- The form will be an agreement between AHCA and the provider to IGT for the State share of the MCO supplemental payment program.
- It will be required to be submitted around **10/01/2019**.
- Typically little flexibility on the language of the form in terms of accommodating changes to the agreement.
- If not submitted by this time, providers will not be eligible to IGT the State share that is needed to draw down federal funding.
- Example LOA form: http://ahca.myflorida.com/Medicaid/Finance/finance/LIP-DSH/LIP/pdfs/SFY_18-19_LIP_LOA.pdf

Overview of Funding Timelines and Frequency of IGTs

- AHCA will notify providers of IGT amounts
- This IGT will be sent to AHCA from providers, in order to draw down the Federal funding
- The providers IGT amount, along with the Federal funding will be passed through the MCOs back to providers.

Quarterly Timeline Example



- Providers should expect a 15 to 45 days until IGT investment and additional federal dollars are realized.

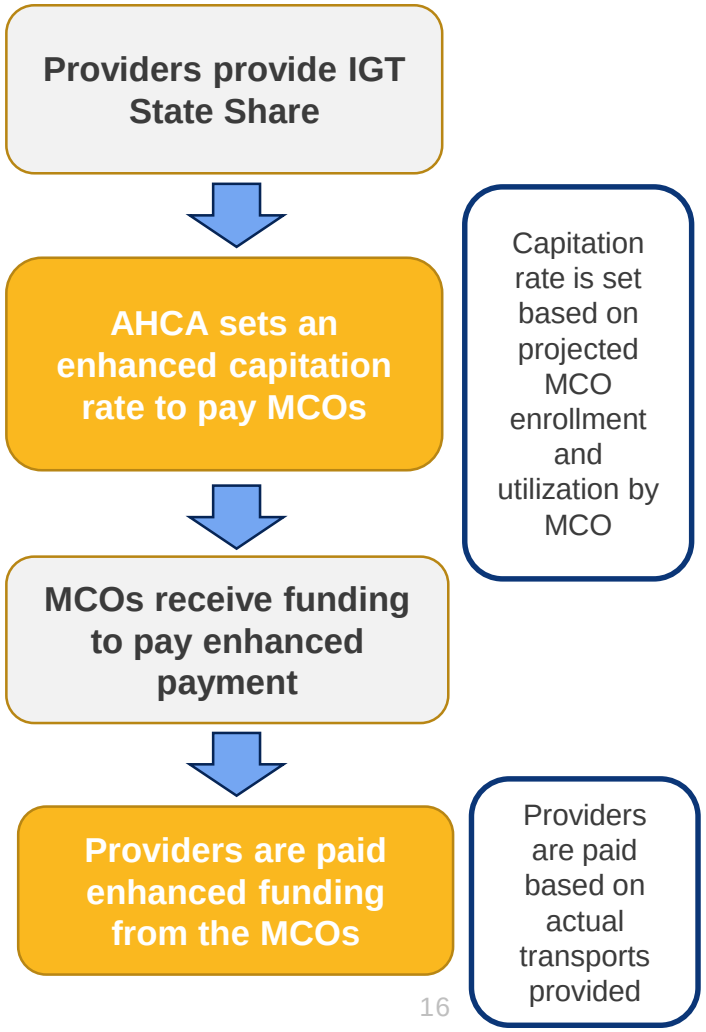
Medicaid Managed Care Supplemental Payment Program Overview

Medicaid Managed Care Supplemental Payment Program

Medicaid Managed Care Supplemental Program will operate differently than the current PEMT program.

- The enhanced funding pool of $54,786,711(all funds) has been established for **qualifying** government owned ambulance providers.
  - Funding will start effective for 10/1/2019 and be paid out quarterly or in accordance with schedule approved by AHCA, pending CMS approval.
- Providers will provide funding of the state share of the pool via a wire transfer or check to the state in the form of an ***Intergovernmental transfer (IGT)***.
- Funding to MCOs will be made through ***establishment of a discrete*** *per member per month premium* ***capitation rate.***
- AHCA will send MCOs the funding to make enhanced rate payments to providers.
- Providers will be paid a ***lump sum supplemental payment*** on a quarterly basis that will be tied to utilization.
- Payment per trip add-ons ***will be consistent across all providers***.

Quarterly Process



Establishment of MCO Funding Pool

PCG and FFCA had to work with AHCA to justify the establishment of the Medicaid MCO funding.

How did we do this?

- PCG leveraged FY17 PEMT cost report data to develop the mechanics of the Medicaid managed care funding pool.
  - The PEMT cost report will be used prospectively to develop and design the Medicaid MCO funding pool.
- PCG calculated Medicaid Managed Care costs using the average cost per trip as determined through the PEMT cost report.
- Medicaid managed care utilization was obtained from the Medicaid data warehouse as reported by the MCOs to AHCA.
- Data suggests a Medicaid managed care pool of ***$415M is justified***, but ultimately only $54M was authorized due to political challenges.
- FFCA will continue to request funding increases over time.

Program	
Medicaid Managed Care Unfunded Costs	**$415,000,000**
Authorized Funding	**$54,786,711**
Funding Authorized	**11.4% of Provider Cost**
Weighted Average Cost Per Trip	**$1,458**
Payment Per Trip (Budget Neutral)*	**$153***

* This represents a projected payment per trip and actual payments will vary slightly based upon utilization.

MCO Funding Pool

The $54.8 million Medicaid managed care funding pool will require provider participation in order to access these funds.

- Providers will need to contribute $21.1 million total (IGT) in order to draw down an additional $35 million in federal funding will be drawn down to providers.

Medicaid MCO Funding Pool	**$54,786,711**
Federal Share (61.47%)	$33,677,391
State Share (38.53%)	**$21,109,320**

- For every $1 a provider contributes to this program, the return is ***$2.60 or a 160% return on investment***.

Payments to MCOs

- Funding to MCOs will be made through the ***establishment of a discrete sub-capitation rate***.
  - MCOs will be **contractually required to pay the enhanced funding to qualifying EMS Providers** through the established distribution model.
  - Payments will be based upon actual provider utilization and therefore there will be no guarantee of funding compared to model projections.

Annual Medicaid Managed Care Funding Pool Projection All Providers	**$54,786,711**
Projected Three Quarters of Medicaid Managed Care Funding Pool	$18,262,237
Projected Average Monthly Medicaid MCO Enrollment	3,848,291
Medicaid MCO Capitation Rate Increase*	$1.58

Capitation rate is subject to change, as it is still being developed with AHCA's actuaries.

- ***Although payments will be made quarterly for the first year of program implementation the entire annual funding pool allotment will need to be paid out in three quarters.***

- The payment methodology is subject to change pending CMS approval

Payments to MCOs

- Quarterly funding pool made to MCOs will be established based upon ***actual Medicaid enrollment*** for each MCO.
  - Funding will increase/decrease as enrollment changes within the Medicaid program.

Quarter 1	Quarterly Members (3 Months)	PMPM	Quarterly Funding Pool
MCO1	4,622,052	$1.58	$7,311,385
MCO2	1,155,513	$1.58	$1,827,846
MCO3	2,311,026	$1.58	$3,655,692
MCO4	577,757	$1.58	$913,923
MCO5	2,888,783	$1.58	$4,569,616
Totals	**11,555,130**	**$1.58**	**$18,278,462**

Amount of funding will vary to MCOs based upon enrollment.

Projected Quarterly MCO Enrollment	**11,544,873**
Variance	10,257

Projected Quarterly MCO Funding	**$18,262,237**
Variance	$16,225

Total funding will also deviate based upon overall enrollment.

However, controls will be put in place by AHCA to ensure *only the approved funding of $54M is expended*.

Medicaid MCO Payments to Providers

Payments to MCOs and MCO Payments to Providers

AHCA will distribute funding to MCOs based upon actual enrollment for the payment quarter.

- AHCA or the MCO, with AHCA oversight, will calculate the Enhanced Payment Per Transport.
- MCOs will have to report the number of transports paid to eligible EMS providers.
- The enhanced payment per trip that will be paid to providers by each MCO, which will be variable by MCO.
- All funding received by the MCOs will contractually be required to be paid out to provider (net of any administrative fees approved by AHCA.

	MCO1	MCO2
PM/PM Capitation Rate	$1.58	$1.58
Medicaid Member Months for the Quarter	4,622,051	1,155,513
EMS Medicaid Managed Care Supplemental Payment Quarterly Pool	$7,311,385	$1,827,846
Medicaid MCO Transports for Qualifying Providers	22,686	8,088
Medicaid MCO Enhanced Payment Per Transport	$322.29	$225.99
Transport to Member Months Ratio	.4908	.6999

MCO Payments to Providers

Please note, the payment process to providers is still fluid and subject to change.

- FFCA and PCG are working with AHCA to finalize the mechanics of payments, as well as CMS will review and potentially have changes to the process.

MCOs will distribute lump sum payments to the provider community on a quarterly basis or approved schedule by AHCA

- MCOs will have to adhere to AHCA's instruction and guidance in terms of payment timelines – More on this later.
- MCOs should make payments consistent with how payments are distributed to providers today during the claims-adjudication process – should be no new account set up.
- This approach should minimize the administrative burden to MCOs, as payments can be processed without changes to claims processing systems.
- Providers will receive payments from multiple MCOs during a quarter depending the region they are located (most would be 5 to 6 based upon plans located in regions, but Region 11 (Dade and Monroe County) has 13 plans).

MCO Payments to Providers

Payments will be made to providers based upon the % of transports the provider rendered in the quarter in relation to total transports paid by the MCO, pending CMS review and approval.

- Transports will be determined based upon date of payment and not date of service.
- For example, when a Medicaid MCO determines the total transports for October to December of 2019, it will include all transports paid during that time period.
- Payment per transport will be the same for every qualifying provider.
- Payment per transport will vary by MCO due to difference in enrollment and volume of transports – Examples to come!

MCO Payments to Providers – Example #1

In this quarter, MCO1 ***received $7.3M in enhanced funding*** to distribute to eligible providers.

	MCO 1			
Quarter1	**Transports**	**% of Transports**	**Pmts**	**Pmt/ Transport**
Prov1	6,804	29.99%	$2,192,684	$322
Prov2	2,720	11.99%	$876,635	$322
Prov3	2,450	10.80%	$789,630	$322
Prov4	2,205	9.72%	$710,667	$322
Prov5	1,983	8.74%	$639,015	$322
Prov6	1,785	7.87%	$575,406	$322
Prov7	1,606	7.08%	$517,646	$322
Prov8	1,445	6.37%	$465,735	$322
Prov9	1,302	5.74%	$419,673	$322
Prov10	386	1.70%	$124,294	$322
Totals	22,686	100.00%	$7,311,385	$322

Payment per transport will deviate from model payment per transport, because transports and member enrollment will vary from model.

Payment per transport will vary quarter to quarter for the same MCO given transports will vary

Funding will match dollars distributed through the sub-capitation rate and enrollment.

- Payment per transport are *consistent across providers*.
- Payments are distributed to each provider based upon their % of total transports.

MCO Payments to Providers – Example #2

In this quarter, MCO2 ***received $1.8M in enhanced funding*** to distribute to eligible providers.

	MCO 2			
Quarter1	**Transports**	**% of Transports**	**Pmts**	**Pmt/ Transport**
Prov1	2,022	25.00%	$456,962	$226
Prov2	1,011	12.50%	$228,481	$226
Prov3	910	11.25%	$205,633	$226
Prov4	819	10.13%	$185,161	$226
Prov5	737	9.11%	$166,517	$226
Prov6	663	8.20%	$149,883	$226
Prov7	597	7.38%	$134,895	$226
Prov8	537	6.64%	$121,369	$226
Prov9	484	5.98%	$109,305	$226
Prov10	307	3.80%	$69,458	$226
Totals	8,088	100.00%	$1,827,846	$226

Payment per transport will deviate from model payment transport , because the funding distributed to each MCO will be fixed, but utilization will vary.

Payment per transport amount will also vary by MCO ($225 versus $322 in prior example).

- This distribution will repeat for each MCO on a quarterly basis.

Provider Specific Fund Flow Examples and Scenarios

MCO Payments to Providers

Things to Know

- The goal is for the Medicaid MCO program to be effective 10/1/2019, however, this timeline is dependent upon CMS approval.
- Providers will receive lump sum payments for transports provided from each MCO in which a provider is contracted with.
- Payments from MCOs to Providers will vary month to month and from MCO to MCO.

MCO Payments to Providers

How the Program will Work

- At the end of each quarter, MCOs will report total transports by provider to AHCA.
  - Transports will be based upon paid transports for that quarterly period.
- AHCA will determine funding to be distributed to each MCO based upon actual Medicaid enrollment.
- AHCA will determine payment by provider for each MCO.
- AHCA will request IGTs from provider community.
- MCOs will receive funding from AHCA.
- MCO payments will be made to providers.

Provider Specific Payment Example #1

This example shows how the Provider will receive payments each quarter from multiple MCOs.

- Payments will vary for a provider across MCOs.
- IGT amounts will correspond to payment to be received from each MCO.

Provider 1	Provider Trips	Total MCO Trips	Provider % of MCO Trips	Quarterly Funding	Payment/ Transport	Payment Due to Provider	IGT request*	Net New Funds Federal Share
MCO 1	324	36,000	.90%	$ 7,311,385	$203.09	$65,802	$25,353	$40,450
MCO 2	2,300	9,500	24.21%	$ 1,827,846	$192.40	$442,531	$170,502	$272,029
MCO 3	234	22,111	1.06%	$ 3,655,692	$165.33	$38,688	$14,906	$23,782
MCO 4	323	7,201	4.49%	$ 913,923	$126.92	$40,994	$15,794	$25,199
MCO 5	876	22,300	3.93%	$ 4,569,616	$204.92	$179,506	$69,162	$110,344
Totals	**4,057**	**97,112**		**$ 18,278,462**	**$188.22**	**$767,522**	**$295,717**	**$471,804**

IGT % = 38.52%

Provider 1 – Model Versus Actuals	
Total Medicaid Managed Care Supplemental Payment	$ 767,522
Projected Medicaid Managed Care Supplemental Payment (Per Model)	$ 705,164
Variance	**$ 62,358**

This provider generated $471,804 in additional Medicaid revenues.

Please note, although payment projections have and can be provided, actual amounts received and required IGT can vary.

Provider Specific Payment Example #2

This example shows how the Provider experience will vary based upon transports and the amounts a provider will receive across the same MCOs.

Provider 2	Provider Trips	Total MCO Trips	Provider % of MCO Trips	Quarterly Funding	Payment/ Transport	Payment Due to Provider	IGT request*	Net New Funds Federal Share
MCO 1	1,251	36,000	3.48%	$ 7,311,385	$203.09	$254,071	$97,891	$156,180
MCO 2	444	9,500	4.67%	$ 1,827,846	$192.40	$85,428	$32,914	$52,513
MCO 3	5,222	22,111	23.62%	$ 3,655,692	$165.33	$863,372	$332,648	$530,725
MCO 4	112	7,201	1.56%	$ 913,923	$126.92	$14,215	$5,477	$8,738
MCO 5	475	22,300	2.13%	$ 4,569,616	$204.92	$97,335	$37,502	$59,833
Totals	**7,504**	**97,112**		**$ 18,278,462**	**$188.22**	**$1,314,420**	**$506,431**	**$807,989**

IGT % = 38.52%

Provider 2	
Total Medicaid Managed Care Supplemental Payment	$ 1,314,420
Projected Medicaid Managed Care Supplemental Payment (Per Model)	$ 1,521,315
Variance	**$ -206,895**

This provider still generated $807,989 in additional Medicaid revenues.

Please note, although payment projections have and can be provided, actual amounts received and required IGT can vary.

Program Requirements in Order to Participate

Program Requirements to Participate

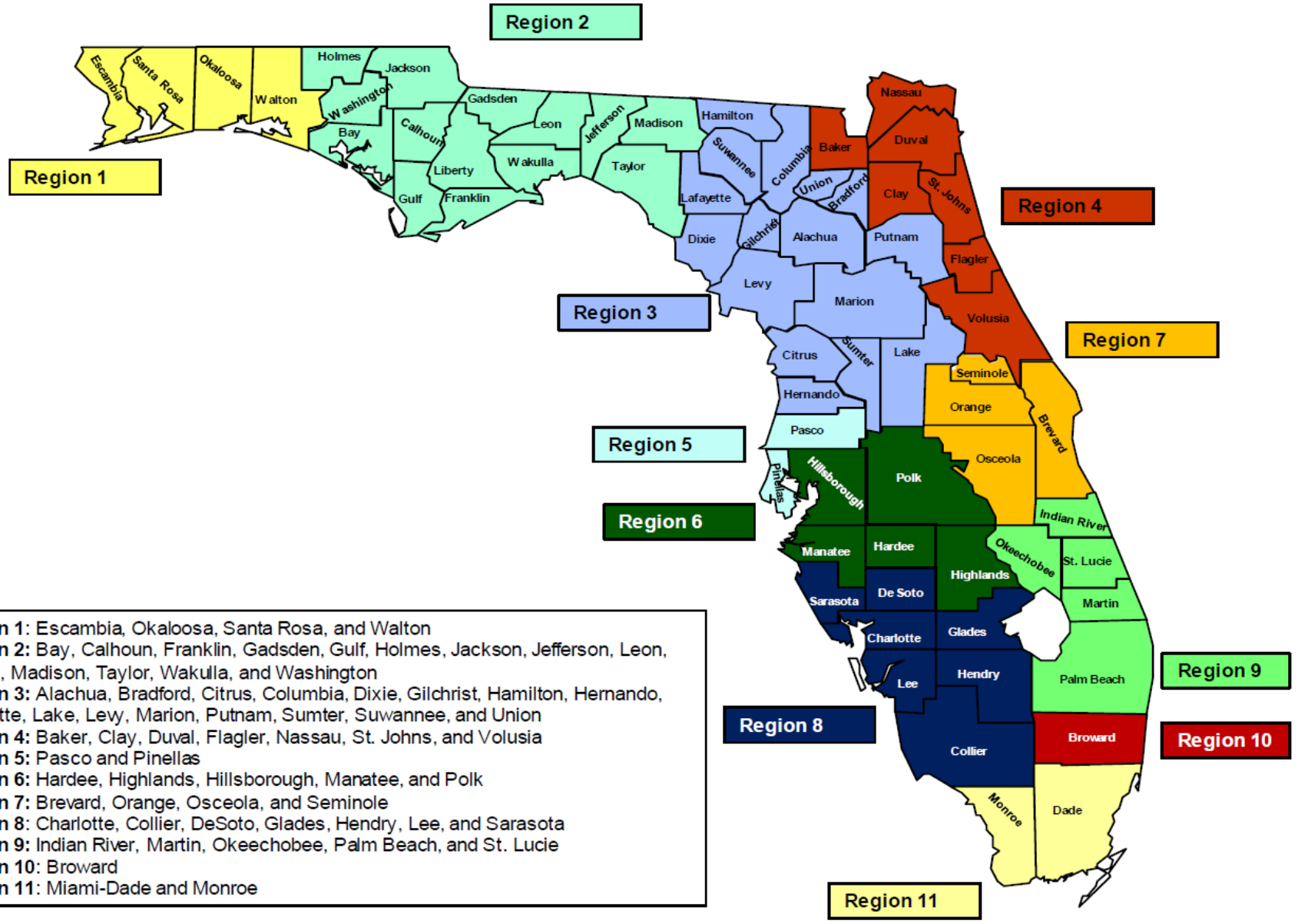
1. Participate in the prior years PEMT program, for this first year that means providers who participated in FY 2017-18
2. Meet the definition of a government owned ambulance provider consistent with the PEMT program requirements.
3. Active NPI number
4. Receive authorization to IGT from governing body and set expectations
5. Sign a Letter of Agreement (LOA) to IGT and participate in a program
6. Contract with all ***Medicaid MCOs*** within your region
    a. AHCA will be assisting in drafting standard contract language for the MCOs to leverage.
    b. If a contract is not executed, the MCO will not be required to make payment to the provider.

Contract With All MCOs in your Region

In order to receive the supplemental payment benefit, all providers will need to contract with the MCOs in their region.

Regions	Aetna Better Health	Humana Medical Plan	Molina Health care	Simply Health care	Staywell	Sunshine Health	United Health care	Vivida Health	Prestige	CCP	Lighthouse Health Plan	Miami Children's	FCC	Clear Health Alliance HIV/AIDs	Magellan Serious Mental Illness	Staywell Serious Mental Illness	Sunshine Health - Child Welfare
Region 1		Comp			Comp	Comp					MMA		LTC+	Spec		Spec	Spec
Region 2		Comp			Comp	Comp					MMA		LTC+	Spec		Spec	Spec
Region 3		Comp			Comp	Comp	Comp						LTC+	Spec		Spec	Spec
Region 4		Comp			Comp	Comp	Comp						LTC+	Spec	Spec	Spec	Spec
Region 5		Comp		Comp	Comp	Comp							LTC+	Spec	Spec	Spec	Spec
Region 6	Comp	Comp		Comp	Comp	Comp	Comp						LTC+	Spec		Spec	Spec
Region 7	Comp	Comp		Comp	Comp	Comp							LTC+	Spec	Spec	Spec	Spec
Region 8		Comp	Comp		Comp	Comp		MMA					LTC+	Spec		Spec	Spec
Region 9		Comp			Comp	Comp			MMA			MMA	LTC+	Spec		Spec	Spec
Region 10		Comp		Comp		Comp				MMA			LTC+	Spec		Spec	Spec
Region 11	Comp	Comp	Comp	Comp	Comp	Comp	Comp		MMA			MMA	LTC+	Spec		Spec	Spec

Provider Regions



Region 1: Escambia, Okaloosa, Santa Rosa, and Walton
Region 2: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington
Region 3: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Lewy, Marion, Putnam, Sumter, Suwannee, and Union
Region 4: Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia
Region 5: Pasco and Pinellas
Region 6: Hardee, Highlands, Hillsborough, Manatee, and Polk
Region 7: Brevard, Orange, Osceola, and Seminole
Region 8: Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
Region 9: Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie
Region 10: Broward
Region 11: Miami-Dade and Monroe

How to Prepare

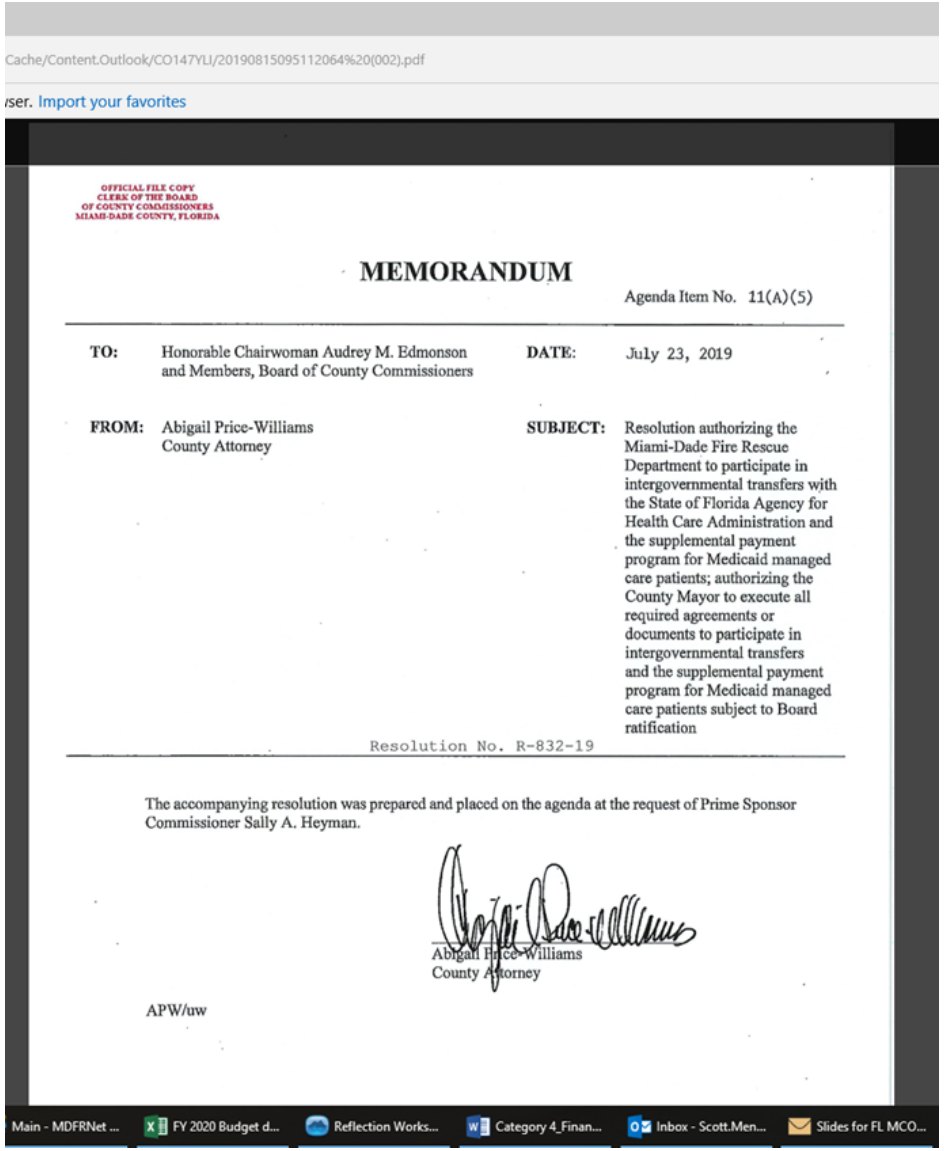
Conversations and approvals that need to occur

Here are some important tips to prepare to participate in the Medicaid Managed Care Supplemental Payment Program

1. Educate your board and governing body on the benefits of the program.
    - Significant increase in Medicaid reimbursement.
    - Provide guidance on how the payments will work both in terms of timing of providing the state share or IGT, as well as when payments received.
2. Talk to your legal Department and prepare them for a review of the LOA.
3. Engage the Medicaid MCOs in your region to have initial contract discussions.
    - Determine what is involved to become an in-network provider.
4. Obtain approval to participate from your board, if applicable.
    - Finance/Accounts Payable staff will need authorization to transfer funds to AHCA
    - Usually a resolution or contract number is required to authorize payments to vendors or contractors
    - The resolution should contain, if legally allowable, the delegation of authority to the Mayor or Manager to execute additional agreements with AHCA and providers.

Setting expectations and obtaining approval with your governing body

- Please reference example memorandum that has been distributed to educate providers on how to obtain formal approval from your governing body.



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CLERK OF THE BOARD
OF COUNTY COMMISSIONERS
MIAMI-DADE COUNTY, FLORIDA

MEMORANDUM

Agenda Item No. 11(A)(5)

TO: Honorable Chairwoman Audrey M. Edmonson and Members, Board of County Commissioners

DATE: July 23, 2019

FROM: Abigail Price-Williams County Attorney

SUBJECT: Resolution authorizing the Miami-Dade Fire Rescue Department to participate in intergovernmental transfers with the State of Florida Agency for Health Care Administration and the supplemental payment program for Medicaid managed care patients; authorizing the County Mayor to execute all required agreements or documents to participate in intergovernmental transfers and the supplemental payment program for Medicaid managed care patients subject to Board ratification

Resolution No. R-832-19

The accompanying resolution was prepared and placed on the agenda at the request of Prime Sponsor Commissioner Sally A. Heyman.

Abigail Price-Williams
County Attorney

APW/uw

Main - MDFRNet ... | FY 2020 Budget d... | Reflection Works... | Category 4_Finan... | Inbox - Scott.Men... | Slides for FL MCO...

Next Steps for AHCA

Next Steps

Immediate

- AHCA submits CFR 438.6 preprint form to CMS for approval
  - This is the document that facilitates the CMS review and approval process.
- CMS typically takes 60 to 90 days to approve forms
- Program would be approved retroactively to October 1, 2019
- AHCA to release Letter of Agreement for providers to fill out and submit in order to participate
- Leverage AHCA template to contract with MCOs if available, regardless engage MCOs immediately.

Ongoing

- Track payments on a quarterly basis
- Update payment model prospectively

Questions and Answer Session

Questions?

Need Additional Help?

Need Additional Help?

PCG can provide technical assistance throughout the planning and approval process.

Our services include:

- Enrolling providers in the Medicaid FFS PEMT program.
- Providing Medicaid cost report services and reimbursement expertise.
- Medicaid managed care payment projection and modeling.
- Training and education assistance in board/governing discussions.
- Assistance and strategies to help with Medicaid MCO contracting.
- Ongoing Medicaid MCO payment analysis and assistance.

Contact Us

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